Assessment Before Travel to the United States of Health Care or Ebola Response Personnel Working in Non-ETU Settings in Areas with Ebola Outbreaks

Worker name: _____ DOB (mm/dd/yyyy): __ /__ /_____

Organization: _____ US destination state: _____

Facility name, location: _____

Dates worked (mm/dd/yyyy): __ /__ /_____ to __ /__ /_____ Staff role: _____

Duties: _____

I certify that I completed this form and the information provided below is accurate to the best of my knowledge.

Worker signature: _____ Date: _____

EXPOSURE ASSESSMENT (To be completed by worker after the last work shift and reviewed by organization's Medical Supervisor. Questions apply to past 21 days.)

Complete the "Known or Potential Exposures" section below if you answer YES to any question in this section.

For all workers in non-ETU (Ebola treatment unit) settings: Had unprotected* exposure to any of the following?

An acutely ill person later diagnosed with Ebola or the person's body fluids ☐ YES ☐ NO

A person who died of Ebola-compatible illness** but not confirmed as having Ebola or the person's body fluids ☐ YES ☐ NO

The body of person who died of Ebola or Ebola-compatible illness** or unknown cause ☐ YES ☐ NO

For workers who did not do clinical or laboratory work, this section is complete.

For health care workers in non-ETU health care facilities:

Provided clinical care to an acutely ill patient later diagnosed with Ebola? ☐ YES ☐ NO

Provided clinical care to a patient who died of Ebola-compatible illness** but not confirmed as having Ebola? ☐ YES ☐ NO

For laboratory workers in non-ETU settings who handled or processed patient specimens:

Processed lab specimens of a patient later diagnosed with Ebola? ☐ YES ☐ NO

Processed specimens of patient who died of Ebola-compatible illness* but not confirmed as having Ebola? ☐ YES ☐ NO

*Unprotected means without use of recommended personal protective equipment (PPE).

**Ebola-compatible illness includes body temperature ≥100.4°F or 38°C or subjective fever, or signs/symptoms including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage.

Known or Potential Exposures (Complete this section if answered YES to any question above.)

Date of incident:__ /__ /_____

Location of incident: _____

Type of exposure:

☐ Needlestick or other sharps injury ☐ Splash to mucous membrane (eye/nose/mouth)

☐ Direct exposure to skin ☐ In close proximity (3 feet / 1 meter) while not using PPE

☐ Other (specify):_____

PPE worn during incident: ☐ none

☐ gloves ☐ gown ☐ face mask ☐ respirator ☐ face shield ☐ eye protection

Describe incident: _____

_____

_____

_____

Action taken: _____

_____

Reviewed by: Name: _____ Title: _____

Organization: _____

Signature: _____ Date: _____

END OF EXPOSURE ASSESSMENT

HEALTH ASSESSMENT (To be completed by Medical Supervisor within 24-48 hours of worker's departure)

Worker name: _____ DOB (mm/dd/yyyy): __ /__ /_____

Date assessment completed: _____ Time: _____

Name of person performing the assessment: _____ Title:_____

Signature: _____

Ebola vaccination status

Ebola vaccine received: ☐ YES ☐ NO

If vaccinated, specify: ☐ Primary prevention ☐ Post-exposure Date of vaccination: __ /__ /_____

Name of vaccine: _____ Lot no._____ Expiration: ___ / ___ / ____

Clinical assessment

Appears well: ☐ YES ☐ NO, specify: _____

_____

Oral temperature measurement: _____ °F / °C

Signs and symptoms in past 48 hours, medication history

Signs/symptoms: ☐ None reported ☐ Fever – if yes, specify: ☐ Not measured (subjective)

Highest temp measured: _____ °F / °C Method: _____ Date: __ /__ /_____ Time: _____

☐ Fatigue ☐ Weakness ☐ Muscle pain ☐ Vomiting ☐ Diarrhea

☐ Abdominal pain ☐ Headache ☐ Joint pain ☐ Sore throat ☐ Difficulty breathing

☐ Chest pain ☐ Unexplained bruising/bleeding

Earliest symptom onset: Date: __ /__ /_____ Time: _____

Use of antipyretic medication(s) in past 12 hours: ☐ None

Name of antipyretic : _____ Dose: _____ Time: _____ Purpose: _____

Name of antipyretic: _____ Dose: _____ Time: _____ Purpose: _____

Was malaria prophylaxis taken as prescribed: YES ☐ NO ☐

Name of antimalarial: _____

END OF HEALTH ASSESSMENT